

Medical Assistance Administration



BLOOD BANK SERVICES

Billing Instructions

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About this publication

This publication supersedes all previous MAA Blook Bank Services Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

**Received too many billing instructions?
Too few?**

Address Incorrect?

Please detach, fill out and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

How Do I Become A DSHS Provider?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H	(360) 664-0300
I-O	(360) 753-4712
P-Z	(360) 753-4711

Where Do I Send Hardcopy Claims?

Division of Program Support
PO Box 9248
Olympia WA 98507-9248

How Do I Request Billing Instructions?

Check out our website:

<http://maa.dshs.wa.gov>

or write/call:

Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800)-562-6188

Where Do I Call If I Have Questions Regarding...

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic Billing?

(360) 753-0318

or write to:

Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

Definitions

This section defines terms and acronyms used in these billing instructions.

Blood Bank - A health care facility that draws blood from voluntary donors, and tests, processes, stores, and distributes human blood and blood components.

Categorically Needy Program (CNP) – Federally-matched Medicaid program(s) that provide the broadest scope of medical coverage. Person may be eligible for CNP only or may also be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. CNP includes full scope of coverage for pregnant women and children.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement – A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department or DSHS – The Washington State Department of Social and Health Services. (WAC 388-500-0005)

Explanation of Benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fraud - An attempt to obtain benefits or payments in a greater amount than that to which a provider is entitled by means of:

- (a) A willful false statement;
- (b) Willful misrepresentation, or by concealment of any material facts; or
- (c) A fraudulent scheme or device, including, but not limited to:
 - (i) Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or
 - (ii) Repeated billing for purportedly covered items, which were not in fact covered.

Internal Control Number (ICN) - A 17-digit number used to identify a claim. This number appears on the Remittance and Status Report near the client's name.

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With, or assigned to, a primary care provider;
- With, or assigned to, a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care.

(WAC 388-538-001).

Maximum Allowable – The maximum dollar amount MAA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320.

(WAC 388-500-0005)

Medical Assistance Administration

(MAA) – The administration within the department of social and health services authorized to administer the acute care portion of the *Title XIX* Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance Identification

(MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medically Necessary – A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section “course of treatment” may include mere observation or, where appropriate, no treatment at all.
(WAC 388-500-0005)

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- a) “Part A” covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- b) “Part B” is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor’s services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

(WAC 388-500-0005)

Patient Identification Code (PIC) – An alphanumeric code that is assigned by MAA to each client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Program Support, Division of (DPS) – The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance and Status Report (RA) – A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Stat Charges – Stat charges are payable when sudden unexpected event occurs which requires immediate action and is needed to manage the patient in a true emergency situation. Limited to one STAT charge per episode; not once per test.

Third Party – Any entity that is, or may be, liable to pay all or part of the medical cost of care of a medical program client. (WAC 388-500-0005)

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment.

This rate *may not exceed*:

- 1) The usual and customary charge that you bill the general public for the same services; or
- 2) If the general public is not served, the rate for the same services normally offered to other contractors.

Washington Administrative Code (WAC)
Codified rules of the State of Washington.

Blood Bank Services

What services do blood banks offer?

Blood banks collect, process, store and supply blood and blood products to facilities that provide blood transfusions. The processing of blood includes all laboratory work required to prepare the product for use. Blood banks also provide blood transfusions if the client is in their facility and provide anti-hemophilic factor to hemophilic clients.

Who is eligible?

All Medicaid clients are eligible for Blood Bank Services.

Are managed care clients eligible?

Blood bank services are covered under managed care. Clients covered under managed care will have a Health Maintenance Organization (HMO) indicator in the HMO column on their MAID card. The managed care plan/provider must arrange or provide all services for a managed care client. The plan's 1-800 telephone number is located on the MAID card.

Coverage

What is covered? (WAC 388-87-045)

- MAA will pay for whole blood or blood derivatives only when they are not available to the patient from other sources.

Limitations:

- ✓ For clients who are covered by Medicare and Medicaid, MAA will pay up to the first three pints of blood or plasma in any spell of illness.
 - ✓ MAA will not pay for blood or blood derivatives that are donated.
- MAA will pay for the service charges necessary in handling and processing blood, plasma, or blood derivatives.

Limitations:

- ✓ If the patient is hospitalized, all charges must be included in the hospital's charges.
 - ✓ After-hours charges, "stat" charges, and weekend charges are not reimbursable.
- Administration of blood or blood derivatives on an outpatient basis in a hospital may be added to the total payment for outpatient service.

Billing

Billing for Blood Transfusions

- Health Care Financing Administration (HCFA) regulations require blood banks to bill the outpatient provider performing a blood transfusion for the blood product processing charge.
- Under Medicaid fee-for-service (FFS), the outpatient provider performing the transfusion must bill MAA for each unit of blood. The relevant blood product procedure codes and the current maximum allowable fees are listed in the fee schedule beginning on page 9.
- The HCPCS blood codes include the collection, processing, and storage of blood. The processing includes all lab work required to prepare the product for use.
- If a blood bank also performs (staff, physician, etc) blood transfusions in its facility, bill using the P-codes on page 16.

What is the time limit for billing?

State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days **after** you provide a service(s). Delivery of a service or product does not guarantee payment.
- **For clients who are not eligible at the time of service, but are later found to be eligible:** Bill MAA within 365 days from the Retroactive¹ or Delayed² certification period.

¹ **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

² **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

- **MAA will not pay if:**
 - ✓ The service or product is not medically necessary;
 - ✓ The service or product is not covered by MAA;
 - ✓ The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; or
 - ✓ MAA is not billed within the time limit indicated above.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at <http://maa.dshs.wa.gov>, or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records does MAA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service(s) provided by the practitioner must be in chronological order. For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Quantity of medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying clients of their rights to make their own health care decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

The Blood Bank Services Fee Schedule (previously found on pages 9-18) is now located in the appendix. To view or download the Fee Schedule, click [Appendix](#).

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How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide. A number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
 - Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
 - You must enter all information within the space allowed.
 - Use upper case (capital letters) for all alpha characters.
 - Do not write, print, or staple any attachments in the bar area at the top of the form.
-

Field Description/Instructions

1a. Insured's I.D. NO.: **Required.**

Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the medical assistance ID card (MAID). This information is obtained from the client's current monthly MAID card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

- 2. Patient's Name: **Required.**** Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

- 3. Patient's Birthdate: **Required.**** Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, federal health insurance benefits, military and veteran's benefits) list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.
5. **Patient's Address: Required.** Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)
9. **Other Insured's Name:** Secondary insurance. If the client has insurance secondary to the insurance listed in *field 11*, enter it here. When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.
- 9A. Enter the other insured's policy or group number *and* his/her Social Security Number.
- 9B. Enter the other insured's date of birth.
- 9C. Enter the other insured's employer's name or school name.
- 9D. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).
10. **Is Patient's Condition Related To: Required.** Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).
11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.
- 11A. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.
- 11B. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.
- 11C. **Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (*Note: This may or may not be associated with a group plan.*)

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc. are inappropriate entries for this field.

11D. Is There Another Health Benefit Plan?: Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d.* If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d** is left blank, the claim may be processed and denied in error.

19. Reserved for Local Use: When applicable, enter indicator **B** to indicate Baby on Parent's PIC. If the client is one of twin or triplets, enter the **B** and indicate the client on the claim as "twin A or B" or "triplet A, B, or C," as appropriate.

21. Diagnosis or Nature of Illness or Injury: When applicable, enter the appropriate diagnosis code(s) in areas 1,2,3, and 4.

22. Medicaid Resubmission: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. Enter only ONE (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 form.

24A. Date(s) of Service: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 04, 1999 = 070499).

Do not use slashes, dashes, or hyphens to separate month, day, year (MMDDYY).

24B. Place of Service: Required. The following is the only appropriate code(s) for Washington State Medicaid:

Code Number To Be Used For

3	Office or center
9	Other

24C. Type of Service: Required. Enter a **3** for all services billed.

24D. Procedures, Services or Supplies CPT/HCPCS: Required. Enter the appropriate procedure code for the services being billed.

24E. Diagnosis Code: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM or V58.2.

24F. \$ Charges: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field.

- 24G. **Days or Units:** **Required.** Enter the total number of days or units for each line. These figures must be whole units.
25. **Federal Tax I.D. Number:** Leave this field blank.
26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Control Number*.
28. **Total Charge:** **Required.** Enter the sum of your charges. Do not use dollar signs or decimals in this field.
29. **Amount Paid:** If you receive an insurance payment or patient paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.
30. **Balance Due:** **Required.** Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.
33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** **Required.** Put the name, address, and telephone # on all claim forms.

Group: Enter the group number assigned by MAA. This is the seven-digit number identifying the entity (i.e., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY		7. INSURED'S ADDRESS (No., Street)	
STATE		CITY	
ZIP CODE		STATE	
TELEPHONE (Include Area Code) ()		ZIP CODE	
TELEPHONE (INCLUDE AREA CODE) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	

14. DATE OF CURRENT: MM DD YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
19. RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER	

A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
From	To					CPT/HCPCS	MODIFIER														
MM	DD	YY	MM	DD	YY																
1																					
2																					
3																					
4																					
5																					
6																					

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. \$ TOTAL CHARGE		29. \$ AMOUNT PAID		30. \$ BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____							

Health & Recovery Services Administration (HRSA)

Blood Banks Fee Schedule

Effective July 1, 2006

Online Correction - August 7, 2006

[Link To Legend For Code Status Indicator](#)

Code Status Indicator	Code	Mod	Comments	Maximum Allowable Fee
R	36415		Corrected Rate Retro 7/1/06	\$2.46
R	36416		Corrected Rate Retro 7/1/06	\$2.46
	36430			\$24.76
	36450			\$72.00
	36511			\$58.70
	36512			\$58.93
	36516			\$2,008.67
	36522			\$803.01
	36550			\$16.05
	38205			\$51.59
	38206			\$51.59
	38207			BR
	38208			BR
	38209			BR
	38210			BR
	38211			BR
	38212			BR
	38213			BR
	38214			BR
	38215			BR
	78120	26		\$7.34
	78120	TC		\$42.88
	78120			\$50.22
	78121	26		\$10.09
	78121	TC		\$71.08
	78121			\$81.40
	82143			\$7.88
	82247			\$5.29
	82248			\$5.29
	82668			\$21.53
	82784			\$10.65
	82803			\$13.96
	83020			\$11.52
	83020	26		\$12.15
	83030			\$9.48
	83890			\$5.60
	83892			\$5.60
	83894			\$5.60
	83896			\$5.60

Health & Recovery Services Administration (HRSA)

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Code Status Indicator	Code	Mod	Comments	Maximum Allowable Fee
	83898			\$23.42
	83912			\$4.59
	83912	26		\$11.47
	84460			\$6.07
	85002			\$5.16
	85013			\$2.71
	85014			\$2.71
	85018			\$2.71
	85032			\$4.93
	85049			\$5.13
	85130			\$13.63
	85210			\$7.04
	85220			\$18.66
	85230			\$15.98
	85240			\$20.52
	85245			\$26.29
	85246			\$26.29
	85247			\$26.29
	85250			\$18.66
	85260			\$20.52
	85270			\$18.66
	85280			\$22.17
	85290			\$18.66
	85291			\$10.18
	85292			\$21.70
	85293			\$21.70
	85300			\$13.57
	85301			\$12.39
	85302			\$13.78
	85303			\$15.84
	85305			\$13.28
	85306			\$17.56
	85307			\$17.56
	85335			\$14.75
	85362			\$7.89
	85366			\$9.86
	85370			\$13.01
	85378			\$8.18

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Code Status Indicator	Code	Mod	Comments	Maximum Allowable Fee
	85384			\$9.21
	85385			\$9.21
	85410			\$8.83
	85420			\$7.49
	85421			\$11.67
	85460			\$2.87
	85461			\$7.59
	85475			\$9.91
	85520			\$15.00
	85576			\$24.61
	85576	26		\$12.38
	85597			\$20.60
	85610			\$4.50
	85635			\$10.02
	85660			\$6.32
	85670			\$6.62
	85705			\$10.81
	85730			\$6.66
	85732			\$7.41
	85999			BR
	86021			\$17.24
	86022			\$17.20
	86023			\$14.27
	86078			\$33.02
	86317			\$15.58
	86329			\$16.09
	86592			\$4.89
	86593			\$5.05
	86644			\$15.07
	86645			\$19.30
	86687			\$9.61
	86688			\$16.05
	86689			\$27.05
	86701			\$10.18
	86702			\$15.48
	86703			\$15.72
	86704			\$13.81
	86705			\$13.48

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Health & Recovery Services Administration (HRSA)

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Code Status Indicator	Code	Mod	Comments	Maximum Allowable Fee
	86706			\$12.31
	86793			\$15.11
	86803			\$16.35
	86804			\$17.74
	86805			\$24.69
	86807			\$23.94
	86821			\$64.68
	86849			BR
	86850			\$7.96
	86860			BR
	86870			BR
	86880			\$6.15
	86885			\$6.55
	86886			\$5.93
R	86890		Corrected Rate Retro 7/1/06	BR
	86891			BR
	86900			\$3.42
	86901			\$3.42
	86903			\$10.82
	86904			\$10.89
	86905			\$4.00
	86906			\$8.52
	86920			BR
	86921			BR
	86922			BR
	86923			BR
	86727		Noncovered Code	BR
	86927			BR
	86930			BR
	86931			BR
	86932			BR
	86940			\$9.40
	86941			\$13.87
	86945			BR
	86950			\$3.74
	86960			BR
	86965			BR
	86970			BR

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